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	HAL049016	A. BUILDING: _____ B. WING _____	R 08/25/2016

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OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Iredell County Department of Social Services conducted a follow-up survey on August 23-25, 2016.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE B VIOLATION Based on these findings, the previous Unabated Type B Violation was abated. Non-compliance continues. Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 5 residents (#1 and #8) observed during a medication pass, and 1 of 5 sampled residents (#1). (Fentanyl, potassium chloride, calcium with vitamin D, aspirin, and Tylenol.) The findings are: A. Review of Resident #1's current FL2 dated 11/17/15 revealed diagnoses included coronary artery disease, angina pectoris, and chronic	{D 358}		

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{D 358}	Continued From page 1 obstructive pulmonary disease. 1. Review of Resident #1's record revealed: -A medication order, "Start fentanyl patch 25mcg/hr every 72 hours, when available from original order date of 6/4/16." (Fentanyl patch is a potent narcotic analgesic used for moderate to severe chronic pain.) -A medication order dated 6/6/16 for Hydrocodone/apap 5/325, 1 tablet every 8 hours as needed for pain. (Hydrocodone/apap is a combination narcotic analgesic used to treat moderate to severe pain.) Review of Resident #1's record revealed: -A subsequent order dated 8/15/16 for "fentanyl patch 25mcg/hr, apply 1 patch every 72 hours (transdermal) when available. OK to apply new patch if previous patch comes off." -A subsequent telephone order dated 8/18/16 and signed by the physician on 8/25/16, "OK to hold fentanyl patch 25mcg/hr until new Rx is sent from pharmacy." Interview with Resident #1's prescribing practitioner on 8/25/16 at 11:15am revealed: -The facility, not the pharmacy, called for refill authorizations on narcotics which require a hard script. -Resident #1 should still be using the fentanyl patch. -He wrote prescriptions on 6/4/16 for 10 fentanyl 25mcg/hr patches and 7/12/16 for 10 fentanyl 25mcg patches for Resident #1. -He could not recall any other scripts written for Resident #1. -He did not recall anyone from the facility had called for refills for Resident #1's fentanyl patch. Interview on 8/24/16 at 2:20pm with Resident #1	{D 358}		

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{D 358}	Continued From page 2	{D 358}		

revealed:
-She was prescribed fentanyl patches every 72 hours for knee pain.
-The fentanyl patches were "very effective" for pain.
-Medication Aide (Staff C) said she should have received a fentanyl patch on 8/21/16, but didn't because she was out of the medication.
-On 8/24/16 Staff C told her Fentanyl patches were ordered on 8/23/16.
-The last time she was administered a Fentanyl patch was 8/18/16.

Interview with Resident #1 on 8/25/16 at 1:45pm revealed:
-She ran out of her fentanyl patch and should have gotten one on 8/21/16.
-She believed the fentanyl patch was on order from the pharmacy.
-She believed she ran out of her fentanyl patch "a couple of days last month," but was not sure of the dates.
-Without the patch, her pain was 6 or 7 (out of a possible 10, with 10 being the worst pain imaginable) on a pain scale even when she took the prn (as needed) hydrocodone/apap 5/325.
-She was pain free with the fentanyl patch.
-Her pain came from a knee joint that needed replacing.

Review of Resident #1's Medication Administration Record (MAR) for June 2016 revealed:
-A handwritten entry for fentanyl transdermal patch 25mcg/hr every 72 hours.
-Fentanyl patches documented as administered on 6/6/16, 6/8/16, 6/11/16, 6/14/16, 6/17/16, 6/20/16, 6/23/16, 6/25/16, and 6/28/16.
-The back of the MAR noted on 6/18/16 and 6/25/16 the patch was applied early due to falling

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{D 358}	Continued From page 3 off in the shower. -No prn hydrocodone/apap 5/325 documented as administered from 6/6/16 through 6/30/16. Review of Resident #1's MAR for July 2016 revealed: -A computer generated entry for fentanyl 25mcg/hr patch, apply 1 patch every 72 hours, (remove old patch) for pain. -The fentanyl patch had been documented as administered on 7/4/16, 7/7/16, 7/10/16, 7/13/16, 7/16/16, 7/19/16, 7/22/16, 7/25/16, 7/28/16, and 7/31/16. -Hydrocodone/apap 5/325 documented as administered 56 times as needed for pain from 7/1/16 through 7/31/16. Review of Resident #1's MAR for August 2016 revealed: -A computer generated entry for fentanyl 25mcg/hr patch, apply 1 patch every 72 hours, (remove old patch) for pain. -The fentanyl patch had been documented as administered on 8/3/16, 8/7/16, 8/10/16, 8/13/16, 8/15/16, and 8/18/16. -Twenty-eight doses of hydrocodone/apap 5/325 documented as administered as needed in August 2016. Interview with the pharmacist at the first pharmacy provider on 8/25/16 at 10:50am revealed: -The only time they had dispensed Resident #1's fentanyl patch was on 6/6/16 for 10 patches, 1 patch every 3 days. -The facility had not called for any refills for Resident #1's fentanyl patch. -Either the facility or the pharmacy can call the prescriber to obtain a hard script for narcotics, but "they have to let us know."	{D 358}		

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{D 358}	Continued From page 4 -They were no longer the pharmacy provider for the facility as of 8/1/16. Interview with the pharmacist at the second pharmacy provider on 8/25/15 at 11:10am revealed: -They had dispensed 3 fentanyl patches 25mcg/hr for Resident #1 on 7/20/16, and 7 patches on 7/21/16. -They had not been contacted by the facility for a refill on Resident #1's fentanyl patch. -Even though they didn't officially take over as pharmacy provider until 8/1/16, if the facility requested medication refills toward the end of July 2016, they sent them. Interview on 8/25/16 at 1:45 pm with Staff C, Medication Aide, revealed: -Resident #1 was the only resident in the facility prescribed fentanyl patches in June, July and August 2016. -Resident #1 was prescribed fentanyl patches every 72 hours in June, July, August 2016. -She administered "most" of Resident #1's fentanyl patches in July 2016. -She remembered signing the July and August 2016 MAR for Resident #1's fentanyl patches. -In July 2016, the pharmacy delivered 7 fentanyl patches to the facility and should have delivered 10. -She did not know why the pharmacy only sent 7 of the 10 prescribed patches. -She could not remember if she called the pharmacy and requested they send the remaining three patches in July 2016. -She administered 5 fentanyl patches to Resident #1 in August 2016. -Resident #1 ran out of fentanyl patches 2-3 days ago and she called the pharmacy for a refill. -The Medication Aides were to order Resident	{D 358}		

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{D 358}	Continued From page 5 #1's patches when she had 3 on hand in the facility. Interview with Administrator on 8/25/16 at 2:50pm revealed: -With the previous pharmacy, "we had to call the doctor for narcotic refills." -With the new pharmacy, they will obtain the narcotic script from the prescriber and send it with the regular medications, if it is a routine medication. Observation of Resident #1's medications on hand on 8/24/16 at 4:10pm revealed no fentanyl patches 25mcg/hr available to administer. Review of the narcotic count sheets for Resident #1's fentanyl patch 25mcg/hr revealed: -Ten patches were sent from the first provider pharmacy on 6/6/16 and the last patch was applied on 7/1/16. -Three patches were sent from the second provider pharmacy on 7/20/16. -Seven patches were sent from the second pharmacy provider on 7/21/16. -No documentation that patches were available to administer or that any were administered from 7/2/16 through 7/19/16 on the narcotic count sheets. Based on review of Resident #1's June and July 2016 MARs and narcotic count sheets and interviews with the pharmacies regarding dispensing and quantity dispensed from 06/06/2016 to 07/20/2016, the facility did not have any fentanyl patches 25mcg/hr available to administer to Resident #1 from 7/7/16 through 7/19/16. 2. Review of Resident #1's current FL2 dated	{D 358}		

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{D 358}	Continued From page 6 11/17/15 revealed a medication order for potassium chloride 10meq each morning. (Potassium chloride is a supplement used to treat low potassium levels.) Observation of the morning medication pass on 8/24/16 at 7:47 am revealed: -Resident #1 received 7 oral medications, but no potassium chloride 10meq. -Resident #1 did not verbally refuse any of her medications during the observed medication pass on 8/24/16 at 7:47am. Interview with Staff A, Medication Aide, on 8/24/16 at 2:43pm revealed Resident #1 had refused her potassium this morning during the observed medication pass. Interview with Resident #1 on 8/25/16 at 1:45pm revealed: -She had refused her potassium in the past, but not recently. -She refused the potassium last month because she was afraid she was getting too much. -Resident #1 wanted a lab test to confirm she needed a potassium supplement. Review of Resident #1's MAR for June, July, and August 2016 revealed: -An entry for potassium chloride 10meq, 1 capsule by mouth each morning with a scheduled administration time of 8am. -The potassium had been initialed as administered every day except 7/17/16 through 7/21/16, and 8/24/16. Review of Resident #1's record revealed a potassium level of 4.8meq/L on 11/16/15, and 4.3meq/L on 7/22/16. (The National Center for Biological Information designates a normal range	{D 358}		

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{D 358}	Continued From page 7 for potassium of 3.5 to 5.5meq/L.) Review of Resident #1's medications on hand on 8/24/16 at 4:15pm revealed: -A bottle of potassium chloride capsules 10meq, 1 capsule each morning, with a dispense date of 7/19/16 for 14 capsules. -Four capsules remained in the bottle. Interview with a Medication Aide at this same time revealed the bottle of 14 potassium chloride 10meq capsules came at the last medication cart exchange on 8/11/16. Refer to review of facility's policy and procedures on medication administration. B. Review of Resident #8's most recent FL2 dated 10/23/15 revealed diagnoses included bipolar disorder, schizophrenia, and emphysema. Review of Resident #8's medication orders from a signed physician's order sheet dated 7/30/16 revealed: -A medication order for aspirin 81mg enteric coated, 1 tablet each morning, with the notation "house stock." (Low dose aspirin is used to prevent blood clots." -A medication order for calcium 600mg with vitamin D, 1 tablet twice daily with a notation "house stock." (Calcium with vitamin D is a supplement used to treat and prevent osteoporosis.) -A medication order for Tylenol 325mg, 2 tablets four times a day. (Tylenol is an analgesic used to treat mild to moderate pain.) Observation of the morning medication pass on 8/24/16 at 8:06am revealed Resident #8 received 9 oral medications, but no aspirin, calcium with	{D 358}		

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{D 358}	Continued From page 8 vitamin D, or Tylenol. Interview with Staff A, Medication Aide, at 8:10am on 8/24/16 revealed: -These 9 observed administered medications were all of Resident #8's 8am medications. -The resident had received no morning medications prior to the observation of this medication pass, and would receive no scheduled 8am medications after the observation of this medication pass. Review of Resident #8's MAR revealed: -An entry for aspirin 81mg enteric coated, 1 tablet each morning, with a scheduled administration time of 8am. -An entry for calcium 600mg with vitamin D 400, with scheduled administration times of 8am and 6pm. -An entry for Tylenol 325mg, 2 tablets four times a day, with scheduled administration times of 8am, 12 noon, 4pm and 8pm. -The Tylenol, aspirin, and calcium with vitamin D had all been initialed as administered on 8/24/16 at 8am. Interview with Resident #8 on 8/24/16 at 11:28am revealed: -She didn't receive her aspirin and calcium with vitamin D this morning, but she believed she received her Tylenol. -The Medication Aides held her Tylenol and aspirin over the past week, because she had surgery yesterday. Interview with Staff A, Medication Aide, on 8/24/16 at 2:43pm revealed: -Resident #8 came to Staff A after the 8am medication pass and asked for her aspirin, calcium with vitamin D, and Tylenol.	{D 358}		

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{D 358}	Continued From page 9 -Staff A administered Resident #8's aspirin, calcium with Vitamin D, and Tylenol because she was still within the time frame of and hour before or and hour after the scheduled administration time. -Staff A did not specify the exact time she gave Resident #8 her aspirin, calcium and vitamin D, and Tylenol. Review of Resident #8's medication on hand on 8/24/16 at 4:10pm revealed: -A plastic cassette containing Tylenol 325mg, labeled 2 tablets four times a day by mouth. -A bulk bottle of house stock aspirin 81mg enteric coated tablets. -A bulk bottle of house stock calcium 600mg and vitamin D 400. Refer to review of facility's policy and procedures for medication administration. _____ Review of the facility's policy and procedures for medication administration revealed: -Medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders. -Staff will provide documentation on the MAR after observing the residents take their medication and before administration to another resident.	{D 358}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the	{D 367}		

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{D 367}	Continued From page 10 following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 3 of 5 sampled residents' (#2, #3, and #5) Medication Administration Records (MARs) were accurate regarding administration of Augmentin, Synthroid, and fentanyl patches. The findings are: A. Review of Resident #2's current FL2 dated 7/2/16 revealed diagnoses included adjustment disorder, mild MR, seizure disorder, obsessive compulsive disorder, and allergic rhinitis. Review of Resident #2's record revealed: -A medication order dated 7/2/16 for prednisone 20mg, 2 tablets daily for 10 days. (Prednisone is a steroid used to treat a variety of conditions including inflammation.)	{D 367}		

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{D 367}	Continued From page 11 -A medication order dated 7/2/16 for Augmentin 875mg, 1 tablet twice daily for 10 days for sinusitis. (Augmentin is a medication used to treat soft tissue, urinary tract, and upper respiratory infections.) Review of Resident #2's Medication Administration Record (MAR) for July 2016 revealed: -A handwritten entry for prednisone 20mg, 2 tablets daily for 10 days, with a scheduled administration time of 8am, and a start date of 7/6/16. -The prednisone 20mg was documented as administered daily from 7/6/16 through 7/15/16. -There was no entry for Augmentin 875mg, 1 tablet daily for 10 days. Interview with the pharmacist at the pharmacy provider on 8/23/16 at 3:02pm revealed they had received the order for the prednisone and Augmentin for Resident #2 on 7/5/16, and sent 20 of each on 7/6/16. Interview with Resident #2 on 8/23/16 at 3:35pm revealed she had received an antibiotic last month, but was not sure of the exact days of the month. Interview with Staff C, Medication Aide, on 8/25/16 at 2:50pm revealed: -She remembered giving Resident #2 an antibiotic last month but could not remember the name of the antibiotic. -She was not sure why it had not been documented on the MAR. Interview with the Administrator on 8/23/16 at 2:30pm revealed she was not sure what had happened with the documentation of Resident	{D 367}		

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{D 367}	Continued From page 12 #2's Augmentin last month, but she would check. Observation of Resident #2's medications on hand at 4:10pm on 8/24/15 revealed no Augmentin or prednisone available to administer. Review of the facility's policy on handling new medication orders revealed: -The secretary faxed new orders to the pharmacy, filed the original order in the resident's record, and gave a copy of the new order to the Medication Aide. -The Medication Aide then reads and interprets the new order, and transcribes it onto the MAR. Refer to interview with Staff B, Medication Aide, on 8/24/16 at 3:45pm. Refer to review of the facility's policy on documentation on the MAR. B. Review of Resident #3's current FL-2 dated 9/28/15 revealed: -A history of urinary tract infections (UTIs). -Incontinence of bowel and bladder. -The resident was non-ambulatory. Review of Resident #3's care plan revealed her requiring total assistance with toileting and transfers. Review of an in-house physician visit note for Resident #3 dated 6/18/16 revealed: -A diagnosis of urinary tract infection. -Orders for a urinalysis and urine culture. -A scheduled follow-up visit in two weeks. Review of a urine culture and sensitivity laboratory report for Resident #3 dated 6/27/16 revealed:	{D 367}		

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{D 367}	Continued From page 13	{D 367}		

-A positive culture for proteus mirabilis.
-A positive culture for gram negative rods.
-Handwritten at the bottom of the report with the attending physician's signature was an order for Augmentin (an antibiotic), 875mg, twice a day for 2 weeks for UTI.
-The hand written date with the signature of 6/30/16.

Review of Resident #3's medication administration record (MAR) for June, 2016 revealed no transcribed order for Augmentin, 875mg twice a day for 2 weeks.

Review of Resident #3's MAR for July, 2016 revealed no transcribed order for Augmentin, 875mg twice a day for 2 weeks.

Review of a urine culture laboratory report for Resident #3 dated 7/15/16 revealed:
-No organism growth.
-The attending physician's signature dated 7/16/16.

Telephone interview on 8/23/16 at 3:10pm with the pharmacist from the forme pharmacy provider revealed his records showed a 14 day treatment course of Augmentin was dispensed and delivered to the facility on 6/30/16.

Telephone interviews on 8/24/16 at 9:03am with Resident #3's Power of Attorney and Family Contact were attempted but unsuccessful.

Interview on 8/24/16 at 2:42pm with Staff A, Medication Aide , revealed:
-Urine culture reports were faxed to the physician who faxed them back to the facility with his orders for antibiotics if indicated.
-The orders were faxed to the Pharmacy with a

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	HAL049016	A. BUILDING: _____ B. WING _____	R 08/25/2016

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OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 14	{D 367}		

call to confirm receipt and the Pharmacy would fill and deliver the prescription.
-The original physician's order would be filed in the resident's record and a copy placed on the resident's MAR for the MA to transcribe the order to the MAR.
-Staff A was not passing medications at the time Resident #3's antibiotic order was given.
-The home health nurse was having to do in-and-out catheterization in order to obtain Resident #3's urine specimen.
-It was possible that the physician order was not communicated to the facility.

Interview with the Administrator on 8/24/16 at 2:45pm revealed she would have expected the order to have been transcribed to the MAR and that when the antibiotic was given the MA would have documented administration on the MAR.

Interview on 8/25/16 at 9:15am with Resident #3 revealed:
-She remembered having a UTI in July and receiving an antibiotic for it.
-She no longer had a UTI and had not had one since July.

Observation on 8/25/16 at 10:40am of Resident #3's medications in the medication cart (accompanied by MA Staff A) revealed no Augmentin among the medications.

Interview on 8/25/16 at 2:20pm of Staff A, Medication Aide revealed:
-She could not recall if Resident #3 received an antibiotic at the end of June and beginning of July, 2016.
-All medications required a transcribed order to the MAR and documentation that it was given.
-She would never give an antibiotic without

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{D 367}	Continued From page 15 documenting it on the MAR. Interview on 8/25/16 at 4:00pm with Staff C, Medication Aide, revealed: -She recalled giving Resident #3 an antibiotic at the end of June and beginning of July, 2016. -She transcribed the order and the remaining date blocks on the MAR after the course of treatment was completed were blocked off. -She could not remember if the antibiotic order was the only one on the MAR page. -Whenever she gave a medication she documented on the MAR that it was given. Review of the facility's policy on handling new medication orders revealed: -The secretary faxed new orders to the pharmacy, filed the original order in the resident's record, and gave a copy of the new order to the Medication Aide. -The Medication Aide then read and interpreted the new order, and transcribed it onto the MAR. Refer to interview with Staff B, Medication Aide, on 8/24/16 at 3:45pm. Refer to review of the facility's policy on documentation on the MAR. C. Review of Resident #5's current FL-2 dated 6/4/16 revealed: -Diagnoses included mental retardation, schizophrenia, chronic obstructive pulmonary disease, obese, hypertension, hypothyroidism.. -A medication order for Synthroid 50mcg, one tablet by mouth every morning on Monday, Tuesday, Thursday, Friday and Saturday and two 50mcg tablets by mouth every morning on Wednesday and Sunday. (Synthroid is a medication used to treat hypothyroidism).	{D 367}		

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{D 367}	Continued From page 16 Review of Resident #5's Medication Administration Record (MAR) for August 2016 revealed: -An entry for Synthroid 50mcg one by mouth daily at 8:00 am on Monday, Tuesday, Thursday, Friday and Saturday. -An entry for Synthroid 50mcg, two by mouth daily at 8:00 am on Wednesday and Sunday. -Both the Synthroid 50mcg one tablet, and Synthroid two tablets entries on the MAR had been initialed as administered every day. Interview on 8/24/16 at 1:30 with Resident #5 revealed she was unaware of which medications she took. Interview on 8/24/16 at 2:40 pm with Staff A, Medication Aide, revealed: -The August 2016 MAR showed Synthroid 50 mcg one by mouth every morning on Monday, Tuesday, Thursday, Friday and Saturday was documented as given daily. -She did not administer Synthroid daily and only gave it on Monday, Thursday, Thursday, Friday and Saturday. -The August 2016 MAR showed Synthroid 50 mcg two by mouth every morning on Wednesday and Sunday was documented as given daily. -She did not administer Synthroid daily and only gave it on Wednesday and Sunday. -In order to keep up with the two separate doses of Synthroid administration on the MAR she "just looked at the MAR to find days to give it". Interview on 8/24/16 at 5:00 pm with Staff B, Medication Aide, revealed: -She was trained by the previous facility manager to sign the MARs every day she worked even if she did not administer the medication.	{D 367}		

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{D 367}	Continued From page 17 -Synthroid came from the previous pharmacy in one cassette with one tablet in each section for Mondays, Tuesdays, Thursdays, Fridays and Saturdays and two tablets in each section for Wednesdays and Sundays. -The facility began using a different pharmacy about a month ago. -The old pharmacy also combined both doses of Synthroid on the June 2016 and July 2016 MARs and she signed the MARs daily as administering both doses. -About a month ago the facility changed pharmacies, and the new pharmacy separated the two doses of Synthroid on the August 2016 MAR. -She continued to sign the August 2016 MAR daily as she had previously signed MARs in June 2016 and July 2016. - When the new pharmacy separated Synthroid on the August 2016 MAR she failed to change the way she documented on the MAR. -She stated "we will need to change the way we're doing it". -She "definitely" did not administer Synthroid 50 mcg one tablet by mouth every day plus two tablets by mouth every day in August 2016. -Nine Synthroid tablets were delivered to the facility on 8/11/16 for Monday, Tuesdays, Thursday, Friday and Saturday, in one cassette and 8 tablets were delivered on 8/11/16 for Wednesday and Sunday in another cassette. Observation of Resident #5's medications on hand on 8/24/16 at 5:30 pm revealed: -One cassette labeled one Synthroid 50mcg tablet daily for Monday, Tuesday, Thursday, Friday and Saturday with one tablet remaining, and two spare tablets on hand. -The other cassette was labeled two Synthroid 50mcg tablets daily for Wednesday and Saturday	{D 367}		

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{D 367}	Continued From page 18 with one tablet remaining and two spare tablets on hand. Refer to interview with Staff B, Medication Aide, on 8/24/16 at 3:45pm. Refer to review of the facility's policy on documentation on the MAR. _____ Interview with Staff B, Medication Aide, on 8/24/16 at 3:45pm revealed: -The Medication Aide on duty was responsible for adding new medication orders to the MAR. -The Administrator and Manager check the accuracy of the MARs. Review of the facility's policy on documentation on the MAR revealed: -The MAR shall be accurate and include the drug name, dose, and directions for administering the medication. -The name and initials of the person administering the medication shall be documented on the MAR. -Omissions and refusals of medications and treatments and the reason for omission shall be documented on the MAR.	{D 367}		